

MRN: _____ Name: _____ DOB: _____

Medical History

Past Medical History (Circle all that apply)

Anxiety	COPD	Hepatitis	Lung Cancer
Arthritis	Coronary Artery Disease	Hypertension	Lymphoma
Asthma	Depression	HIV/AIDS	Prostate Cancer
Atrial Fibrillation	Diabetes	Hypercholesterolemia	Radiation Treatment
BPH	End Stage Renal Disease	Hyperthyroidism	Seizures
Breast Cancer	GERD	Hypothyroidism	Stroke
Colon Cancer	Hearing Loss	Leukemia	Other: _____

Past Surgeries: _____

Skin History (Circle all that apply)

Acne	Blistering Sunburns	Hay Fever or Allergies	Psoriasis
Actinic Keratosis	Dry Skin	Melanoma	Squamous Cell Carcinoma
Asthma	Eczema	Poison Ivy	Other: _____
Basal Cell Carcinoma	Flaking or Itchy Scalp	Precancerous Moles	_____

Do you wear sunscreen? YES NO SPF: _____

Family History of Skin Cancer? YES NO

If YES, which relative? _____

If YES, which type? (Please Circle): BASAL CELL SQUAMOUS CELL MELANOMA UNKNOWN

Are you currently taking any medications? YES (Please List) NO

Are you allergic to any medications? YES (Please list) NO

Vaccinations (Month/Year Received):

Pneumonia: ____/____

Flu Shot: ____/____

Alcohol Usage (Please Circle): NONE LESS THAN 1 PER DAY 1-2 PER DAY 3+PER DAY

Smoking Status (Please Circle): EVERY DAY SOME DAYS FORMER SMOKER NEVER SMOKER

Height: _____ Weight: _____

Please circle any that you currently have (ROS):

High Blood Pressure	Thyroid Problems	Asthma/Hay Fever	Rash	Muscle weakness
Chest Pain	Anemia	Emphysema	Immunosuppression	Neck stiffness
Heart Attack	Blood transfusion	Malaise (Feel Sick)	Night sweats	Seizures
Shortness of breath	Cancer	Fever or Chills	Sore throat	Cough
Stroke	Multiple Sclerosis (Numb)	Headache	Blurry Vision	Wheezing
Unintentional Weight Loss	Lupus	Problems with bleeding	Abdominal Pain	Anxiety
Depression	Arthritis/Muscle Pain	Problems with healing	Bloody Stool	
Diabetes	Rheumatic Disease	Problems with scarring	Bloody Urine	

Artificial joints	Tuberculosis	Kidney problems	Blood thinners
Artificial heart valve	AIDS/HIV	Allergy to Lidocaine	MRSA
Pacemaker/defibrillator	Hepatitis B or C	Allergy to adhesive/latex	Rapid heart beat w/ epinephrine
Blood clots	Liver problems	Allergy to antibiotic ointment	Pregnant or Planning pregnancy

Patient/Legal Guardian Signature: _____ Date: _____